ILLINOIS DEPARTMENT OF Healthcare and Family Services

Erythropoietic Support Agents
Prior Authorization Criteria

Aranesp® (darboepoetin), Epogen® and Procrit® (epoetin alfa), Omontys® (peginesatide)

All prescriptions for erythropoietic support agents (ESA) will require Prior Authorization to ensure appropriate utilization.

Prior Approval Criteria

Approval will be given for ESA agents that meet the approval criteria. **Initial approval** will be given for a period of 6 months for a diagnosis of anemia associated with chronic kidney disease (CKD) and a period of 2 months for anemia associated with other conditions. **Renewals** will be granted based on demonstrated response to treatment. Patients receiving chemotherapy who do not respond with improved hemoglobin (Hgb) levels, or who still require RBC transfusions after 2 months will not be eligible for prior authorization renewal.

Darbepoetin alfa (Aranesp*) will be approved for the treatment of anemia in patients with adequate iron stores for the following conditions:

1. CKD in an individual with a Hgb <10 g/dL.
2. Cancer chemotherapy-induced anemia with a Hgb < 10 g/dL when additional chemotherapy is scheduled. **Only prescribers enrolled in the ESA APPRISE Oncology Program may prescribe and/or dispense.**

Epoetin alfa (Epogen, Procrit*) will be approved for the treatment of anemia in patients with adequate iron stores for the following indications:

1. CKD in a client with a Hgb <10 g/dL.
2. Cancer chemotherapy-induced anemia with a Hgb approaching or < 10g/dL when additional chemotherapy is scheduled. **Only prescribers enrolled in the ESA APPRISE Oncology Program may prescribe and/or dispense.**
3. Reduction of allogeneic RBC transfusions in clients undergoing elective, non-cardiac, non-vascular surgery.
4. HIV infected clients receiving zidovudine treatment.

Peginesatide (Omontys) will be approved for the treatment of anemia in patients with adequate iron stores for the following condition when justification is supplied documenting contraindication to the preferred agents:

1. CKD in adult clients ON dialysis, with a Hgb <10 g/dL, who have failed treatment with epoetin alfa and darbopoetin or where justification is provided by the provider describing why epoetin alfa and darbopoetin are not appropriate therapy.

*** Preferred with Prior Authorization**